TERMINATION OF HEALTH INSURANCE COVERAGE

Note: Do not use this form to drop dependents or to change the status of an active employee to a retiree – use a MACoHCT Change Form.

Group Name: _____

Group Number:_____

Employee's Full Name:_____

Employee's Social Security Number:_____

Employee's Last Known Address:_____

_____

Date of Qualifying Event: _____
(Indicate exact date employee becomes ineligible for coverage. Coverage will end the last day of the month in which the Qualifying Event takes place.)

Type of Qualifying Event: _____ **Form Completed By:**_____
(Indicate number from list below) (Name of county employee completing this form)

1. Involuntary Termination of Employment (employee laid-off or let-go)
2. Voluntary Termination of Employment (employee willingly resigned)
3. Reduction in Hours Worked to less than 20 (or 17.5*) hours a week
4. Voluntarily Dropping Coverage and still working at least 20 (or 17.5*) hours a week
5. Dropping Coverage due to Retirement
6. Dropping Coverage due to Medicare or Other Insurance
7. Ineligible for Coverage due to Military Service
8. Ineligible for Coverage due to Disability under Social Security
9. Employee Death
10. Other:_____
(Please give detailed explanation so MACoHCT can determine COBRA eligibility)

**Please refer to page 1 of your Participation & Affiliation Agreement to determine if active employees in your Member Group are required to work a minimum of 20 or 17.5 hours a week to be eligible for health insurance coverage thru MACoHCT.*

Please Send Completed Form To:
MACo Health Care Trust
Attn: Enrollment Specialist
2717 Skyway Drive, Suite D
Helena, MT 59602
Phone: 1-866-669-6428 **Fax:** (406) 443-8103

For MACoHCT USE ONLY:
Date Entered____/____/____ By_____

Form Updated: 3/2010